

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3170AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER FELIS CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1042 FEATHERWOOD AVE HENDERSON, NV 89015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	<p>Initial Comments</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 6/11/09 and completed on 6/12/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.</p> <p>The facility is licensed for 7 Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was 4. Four resident files were reviewed and 2 employee files were reviewed. The facility received a grade of D.</p> <p>Complaint #22113 was substantiated. See Tags Y 272, Y 274, Y 755, Y 858</p> <p>The following deficiencies were identified:</p>	Y 000		
Y 050 SS=F	<p>449.194(1) Administrator's Responsibilities-Oversight</p> <p>NAC 449.194 The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.2766, inclusive, and chapter 449 of NRS.</p>	Y 050		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3170AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER FELIS CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1042 FEATHERWOOD AVE HENDERSON, NV 89015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 053	Continued From page 2 Please refer to Tags Y72, Y 195, Y 106, Y859, Y 878, Y 898 and Y 936. This was a repeat deficiency from the 11/21/08 State Licensure survey. Severity: 2 Scope: 3	Y 053		
Y 072 SS=F	449.196(3) Qualications of Caregiver-Med Training NAC 449.196 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of training in the management of medication. The caregiver must receive the training at least every 3 years and provide the residential facility with satisfactory evidence of the content of the training and his attendance at the training; and (b) At least every 3 years, pass an examination relating to the management of medication approved by the Bureau. This Regulation is not met as evidenced by: Based on record review on 6/11/09, the facility failed to ensure that 2 of 2 caregivers had completed the required three hour medication management refresher training every three years (Employee #1 and #2).	Y 072		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3170AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER FELIS CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1042 FEATHERWOOD AVE HENDERSON, NV 89015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 072	Continued From page 3 This was a repeat deficiency from the 11/21/08 State Licensure survey. Severity: 2 Scope: 3	Y 072			
Y 105 SS=F	449.200(1)(f) Personnel File - Background Check NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. This Regulation is not met as evidenced by: Based on record review on 6/11 and 6/12/09, the facility failed to ensure 2 of 2 caregivers met background check requirements (Employee #1 and #2). This was a repeat deficiency from the 11/21/08 State Licensure survey. Severity: 2 Scope: 3	Y 105			
Y 106 SS=F	449.200(2)(a) Personnel File - 1st aid & CPR NAC 449.200 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1, (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation.	Y 106			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3170AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER FELIS CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1042 FEATHERWOOD AVE HENDERSON, NV 89015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 106	Continued From page 4 This Regulation is not met as evidenced by: Based on record review on 6/11/09, the facility failed to ensure that 1 of 2 caregivers were trained in first aid and cardiopulmonary resuscitation (Employee #2). This was a repeat deficiency from the 11/21/08 State Licensure survey. Severity: 2 Scope: 3	Y 106		
Y 151 SS=F	449.204(1)(b) Insurance NAC 449.204 1. A residential facility shall: (b) Maintain a contract of insurance for protection against liability to third persons in amounts appropriate for the protection of residents, employees, volunteers and visitors to the facility. This Regulation is not met as evidenced by: Based on observation and interview on 6/11/09, the facility failed to ensure the facility was insured. This is a repeat deficiency from the 11/21/08 State Licensure Survey. Severity: 2 Scope: 3	Y 151		
Y 152 SS=C	449.204(2) Insurance-BLC endorsement	Y 152		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3170AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER FELIS CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1042 FEATHERWOOD AVE HENDERSON, NV 89015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 152	Continued From page 5 NAC 449.204 2. A certificate of insurance must be furnished to the Division as evidence that the contract required by subsection 1 is in force and a license must not be issued until that certificate is furnished. Each contract of insurance must contain an endorsement providing for a notice of 30 days to the bureau before the effective date of a cancellation or nonrenewal of the policy. This Regulation is not met as evidenced by: Based on interview on 6/11/09, the facility failed to comply with NAC 449.204 with regard to maintaining a current and acceptable certificate of liability insurance with an endorsement to notice the Health Division. Severity: 1 Scope: 3	Y 152		
Y 272 SS=C	449.2175(3) Service of Food - Menus NAC 449.2175 3. Menus must be in writing, planned a week in advance, dated, posted and kept on file for 90 days. This Regulation is not met as evidenced by: Based on observation and interview on 6/11/09, the facility failed to ensure a planned, dated and posted menu was utilized. Severity: 1 Scope: 3	Y 272		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3170AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER FELIS CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1042 FEATHERWOOD AVE HENDERSON, NV 89015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 276	Continued From page 6	Y 276			
Y 276 SS=F	<p>449.2175(7) Nutrition and Service of Food</p> <p>NAC 449.2175</p> <p>7. Meals must be nutritious, served in an appropriate manner, suitable for the residents and prepared with regard for individual preferences and religious requirements. At least three meals a day must be served at regular intervals. The times at which meals will be served must be posted. Not more than 14 hours may elapse between the meal in the evening and breakfast the next day. Snacks must be made available between meals for the residents who are not prohibited by their physicians from eating between meals.</p> <p>This Regulation is not met as evidenced by: Based on observation and interview on 6/11/09, the facility failed to provide nutritious meals and snacks between meals for 4 of 4 residents.</p> <p>Severity: 2 Scope: 3</p>	Y 276			
Y 755 SS=D	<p>449.2722(3)(a)-(f) Bowel & Bladder Incontinence</p> <p>NAC 449.2722</p> <p>3. The caregivers employed by a residential facility with a resident who has a manageable condition of bowel or bladder incontinence shall ensure that:</p> <p>(a) If the resident can benefit from scheduled toileting, he is assisted or reminded to go to the bathroom at regular intervals.</p> <p>(b) The resident is checked during those periods when he is known to be incontinent, including</p>	Y 755			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3170AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER FELIS CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1042 FEATHERWOOD AVE HENDERSON, NV 89015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 755	Continued From page 7 during the night; (c) The resident is kept clean and dry; (d) Retraining programs are designed by a medical professional with training and experience in the care of persons with bowel or bladder dysfunction; (e) The retraining programs established for a resident are followed; and (f) Privacy is afforded to the resident when care is being provided. This Regulation is not met as evidenced by: Based on record review and interview on 6/11/09, the facility failed to provide assistance to the bathroom and to keep Resident #1 clean and dry. Severity: 2 Scope: 1	Y 755		
Y 858 SS=D	449.274(4)(c) Medical Care / Records NAC 449.274 4. the facility shall ensure that appropriate medical care is provided to the resident by: (c) A medical professional. This Regulation is not met as evidenced by: Based on record review and interview on 6/11/09 and 6/12/09, the facility failed to provide medical care for 1 of 4 residents by not providing	Y 858		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3170AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER FELIS CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1042 FEATHERWOOD AVE HENDERSON, NV 89015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 858	Continued From page 8 transportation to dialysis treatment on 6/1/09 for Resident #2. Severity: 2 Scope: 1	Y 858			
Y 859 SS=E	449.274(5) Periodic Physical examination of a resident NAC 449.274 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his physician. The resident must be cared for pursuant to any instructions provided by the resident's physician. This Regulation is not met as evidenced by: Based on record review on 6/11/09, the facility failed to ensure that 2 of 4 residents received a physical prior to admission (Resident #2 and #4). This was a repeat deficiency from th 11/21/08 State Licensure Survey. Severity: 2 Scope: 2	Y 859			
Y 878 SS=F	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this	Y 878			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3170AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2009
NAME OF PROVIDER OR SUPPLIER FELIS CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1042 FEATHERWOOD AVE HENDERSON, NV 89015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 898	Continued From page 10 This Regulation is not met as evidenced by: Based on record review and interview on 6/11/09, the facility failed to ensure the instructions for administering medication reflected the physician order for 3 of 4 residents (Resident #2, #3 and #4). Scope: 1 Severity: 3	Y 898		
Y 936 SS=F	449.2749(1)(e) Resident file NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. This Regulation is not met as evidenced by: Based on record review on xxxx, the facility failed to ensure 2 of 4 residents complied with NAC 441A.380 regarding tuberculosis testing (Resident #2 and #4) which affected all residents. This was a repeat deficiency from the 11/21/08 State Licensure survey. Severity: 2 Scope: 3	Y 936		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.